AMENDED IN ASSEMBLY APRIL 21, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 1454

Introduced by Assembly Member Calderon

February 22, 2005

~~An act to amend Section 139.31 of the Labor Code, relating to workers' compensation.~~ *An act to add Chapter 11.2 (commencing with Section 679.8) to Part 1 of Division 1 of the Insurance Code, relating to homeowners' insurance.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1454, as amended, Calderon. ~~Workers' compensation: outpatient surgical centers: referrals~~ *Homeowners' insurance: prohibited actions*.

Existing law generally regulates homeowners' insurance. Existing law imposes various obligations on insurers with respect to the determination of insurance rates.

This bill would impose various requirements on an insurer that uses credit information in underwriting or rating a consumer of homeowners' insurance, including requirements relating to denials of applications, cancellation or nonrenewal of policies, setting of rates, discrimination, prohibited credit factors, updated credit reports, and notification of adverse actions.

Existing law prohibits an insurer from basing an adverse underwriting decision, as defined, on the fact that an individual has previously inquired and received information about the scope or nature of coverage under a residential fire or property insurance policy, if the information is received from an insurance-support organization whose primary source of information is insurance institutions and the inquiry did not result in the filing of a claim.

This bill would prohibit an insurer from reporting the fact that an insured has inquired about the nature or scope of coverage under a homeowners' policy to a database or other record maintained by any of these insurance-support organizations if the inquiry did not result in the filing of a claim.

~~Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of employment.~~

~~Existing law provides that it is unlawful for a physician to refer a person for medical goods or services, including outpatient surgery services, whether for treatment or medical–legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.~~

~~Existing law also provides for an exemption from this prohibition for outpatient surgical centers when the referring physician obtains a service preauthorization from the insurer or self–insured employer after disclosure of the financial relationship.~~

~~This bill would make various technical, nonsubstantive changes to these provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 139.31 of the Labor Code is amended to read:~~

SECTION 1. Chapter 11.2 (commencing with Section 679.8) is added to Part 1 of Division 1 of the Insurance Code, to read:

CHAPTER 11.2. HOMEOWNERS' BILL OF RIGHTS

679.8. (a) This section shall apply to policies that are subject to Section 675.

(b) (1) If an insurer uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with the application. This disclosure shall be either written or provided to an applicant in the same medium as the

application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy if the insured has previously been provided a disclosure statement.

(2) Use of the following sample disclosure statement shall constitute compliance with this subdivision: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third-party in connection with the development of your insurance score."

(c) An insurer may not deny an application for insurance solely on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information.

(d) After a policy has been in effect for 60 days, an insurer may not cancel or nonrenew the policy based, in whole or in part, on a consumer's credit information or insurance score.

(e) An insurer may not base a rate solely upon credit information, without consideration of any other applicable factor independent of credit information.

(f) An insurer may not use an insurance score that is calculated using the income, age, sex, address, ZIP Code, census block, ethnic group, religion, marital status, or nationality of the consumer as a factor.

(g) An insurer may not give any underwriting or rating consideration to the absence of credit information or the inability to calculate an insurance score for a consumer.

(h) The following factors may not be used for the development of an insurance score or in reviewing credit information for the purpose of underwriting or rating:

(1) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information.

(2) Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

(3) Collection accounts with a medical industry code, if so identified on the consumer's credit report.

(4) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from

the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered.

(5) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

(6) The consumer's total available line of credit. However, the consumer's ratio of debt to total available line of credit may be considered.

(i) An insurer shall, upon request of the applicant or insured, provide reasonable underwriting exceptions for persons whose credit information is unduly influenced by expenses related to a catastrophic injury or illness, temporary loss of employment, the death of an immediate family member, divorce, or other extraordinary circumstance. The insurer may require reasonable documentation of these events prior to granting an exception.

(j) An insurer may not take an adverse action against a consumer based on credit information, unless the insurer obtains and uses a credit report issued, or an insurance score calculated, within 90 days from the date the policy is first written or renewal is issued.

(k) An insurer may not use credit information unless, not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Notwithstanding this requirement, the following provisions apply:

(1) At annual renewal, upon the request of the consumer or the consumer's agent, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer shall not be required to recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a 12-month period.

(2) The insurer may obtain current credit information upon any renewal before the 36-month period expires if consistent with its underwriting guidelines.

(l) Notwithstanding any other provision of this section, an insurer is not required to obtain current credit information for an insured if any of the following applies:

(1) The insurer is acting toward the consumer in a manner that has been approved by the commissioner.

(2) The insured is in the most favorably priced tier of the rate structure used by the insurer and any affiliated insurers. However, the insurer may order a credit report if consistent with its underwriting guidelines.

(3) Credit was not used for underwriting or rating the insured when the policy was initially written. However, the insurer may use credit for underwriting or rating the insured upon renewal if consistent with its underwriting guidelines and the requirements of this section.

(4) The insurer reevaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(m) An insurer may not use an insurance score derived from an insurance scoring model to determine eligibility for an insurance payment plan.

(n) If an insurer takes an adverse action based upon credit information, the insurer shall do each of the following:

(1) Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of Section 1681m(a) of Title 15 of the United States Code.

(2) Provide notification to the consumer explaining the reason for the adverse action. The reasons shall be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take the adverse action. The notification shall include a description of up to four factors that were the primary reasons for the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" does not meet the explanation requirements of this paragraph. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors shall be deemed to comply with this section.

(o) If it is determined through the dispute resolution process set forth in Section 1681i(a)(5) of Title 15 of the United States Code that the credit information of an applicant or a current insured was incorrect or incomplete, and if the insurer receives notice of that determination from either the consumer reporting agency or from the applicant or insured, the insurer shall reunderwrite and rerate the consumer within 30 days of

receiving the notice. After reunderwriting or rerating the applicant or insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

(p) An insurer shall indemnify, defend, and hold harmless an agent from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of the agent in connection with obtaining or using credit information or insurance scores for the insurer, provided the agent follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this subdivision shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this subdivision.

(q) (1) An insurance score may not be used to determine rates or premiums, or to make underwriting decisions, unless the insurance scoring model on which the insurance score is based is filed with the commissioner. Insurance scoring models include all attributes and factors used in the calculation of an insurance score, statistical validation, documentation, appropriate loss information, and any other relevant factors.

(2) Information filed under paragraph (1) is confidential and shall be considered a trade secret pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(r) For the purposes of this section, the following words have the following meanings:

(1) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

(2) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(3) "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer.

(4) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

(5) "Consumer reporting agency" means any person who, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(7) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity that is used or expected to be used, or collected in whole or in part, for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

679.82. An insurer shall not report the fact that an insured has inquired about the nature or scope of coverage under a policy specified in Section 675 to a database or other record maintained by an insurance-support organization whose primary source of information is insurance institutions if the inquiry did not result in the filing of a claim.

~~139.31. The prohibition of Section 139.3 shall not apply to or restrict any of the following:~~

~~(a) A physician may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 139.3 if the physician's regular practice is where there is no alternative~~

~~provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. A physician who refers to, or seeks consultation from, an organization in which the physician has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.~~

~~(b) A physician who has one or more of the following arrangements with another physician, a person, or an entity, is not prohibited from referring a patient to the physician, person, or entity because of the arrangement:~~

~~(1) A loan between a physician and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.~~

~~(2) A lease of space or equipment between a physician and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.~~

~~(3) A physician's ownership of corporate investment securities, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the physician's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any physicians who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, total gross assets exceeding one hundred million dollars ($100,000,000).~~

~~(4) A personal services arrangement between a physician or an immediate family member of the physician and the recipient of the referral if the arrangement meets all of the following requirements:~~

~~(A) It is set out in writing and is signed by the parties.~~

~~(B) It specifies all of the services to be provided by the physician or an immediate family member of the physician.~~

~~(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.~~

~~(D) A written notice disclosing the existence of the personal services arrangement and including information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee, is provided to the following persons at the time any services pursuant to the arrangement are first provided:~~

~~(i) An injured worker who is referred by a licensee or an immediate family member of the licensee.~~

~~(ii) The injured worker's employer, if self-insured.~~

~~(iii) The injured worker's employer's insurer, if insured.~~

~~(iv) If the injured worker is known by the licensee or the recipient of the referral to be represented, the injured worker's attorney.~~

~~(E) The term of the arrangement is for at least one year.~~

~~(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties, except that if the services provided pursuant to the arrangement include medical services provided under Division 4 (commencing with Section 3200), compensation paid for the services shall be subject to the official medical fee schedule promulgated pursuant to Section 5307.1 or subject to any contract authorized by Section 5307.11.~~

~~(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.~~

~~(c) (1) A physician may refer a person to a health facility as defined in Section 1250 of the Health and Safety Code, to any facility owned or leased by a health facility, or to an outpatient surgical center, if the recipient of the referral does not compensate the physician for the patient referral, and any equipment lease arrangement between the physician and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).~~

~~(2) Nothing shall preclude this subdivision from applying to a physician solely because the physician has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.~~

~~(3) A physician may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code. For nonemergency outpatient diagnostic imaging services performed with equipment for which, when new, has a commercial retail price of four hundred thousand dollars ($400,000) or more, the referring physician shall obtain a service preauthorization from the insurer, or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.~~

~~(d) A physician compensated or employed by a university may refer a person to any facility owned or operated by the university, or for a physician service, to another physician employed by the university, provided that the facility or university does not compensate the referring physician for the patient referral. For nonemergency diagnostic imaging services performed with equipment that, when new, has a commercial retail price of four hundred thousand dollars ($400,000) or more, the referring physician shall obtain a service preauthorization from the insurer or self-insured employer. An oral authorization shall be memorialized in writing within five business days. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physician for those referrals.~~

~~(e) The prohibition of Section 139.3 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a physician's office, or the office of a group practice. Further, the provisions of Section 139.3 shall not alter, limit, or expand a physician's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice. With respect to diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars ($400,000) or more, or for physical therapy services, or for psychometric testing that exceeds the routine screening battery protocols, with a time limit~~

~~of two to five hours, established by the administrative director, the referring physician obtains a service preauthorization from the insurer or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.~~

~~(f) The prohibition of Section 139.3 shall not apply when the physician is in a group practice as defined in Section 139.3 and refers a person for services specified in Section 139.3 to a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code. For diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars ($400,000) or more, or physical therapy services, or psychometric testing that exceeds the routine screening battery protocols, with a time limit of two to five hours, established by the administrative director, performed at the multispecialty facility, the referring physician shall obtain a service preauthorization from the insurer or self–insured employer. Any oral authorization shall be memorialized in writing within five business days.~~

~~(g) The requirement for preauthorization in Sections (e), (e), and (f) shall not apply to a patient for whom the physician or group accepts payment on a capitated risk basis.~~

~~(h) The prohibition of Section 139.3 shall not apply to any facility when used to provide health care services to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).~~

~~(i) The prohibition of Section 139.3 shall not apply to an outpatient surgical center, as defined in paragraph (7) of subdivision (b) of Section 139.3, when the referring physician obtains a service preauthorization from the insurer or self-insured employer upon disclosure of the financial relationship.~~

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